INTERIM REPORT

TO SIXTY-FOURTH
GENERAL ASSEMBLY
SPRINGFIELD, ILLINOIS
JUNE 7, 1945

DWIGHT H. GREEN
Governor

COMMITTEE TO INVESTIGATE CHRONIC DISEASES AMONG INDIGENTS ••••••

ESTABLISHED BY ACT OF THE
SIXTY-THIRD GENERAL
ASSEMBLY

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COMMITTEE TO INVESTIGATE CHRONIC DISEASES AMONG INDIGENTS.....

Established by Act of the Sixty-third
General Assembly

MEMBERS OF THE COMMITTEE

SENATOR ARTHUR J. BIDWILL, *Chairman*
River Forest

SENATOR T. MAC DOWNING
Macomb

SENATOR ALBERT L. SCHWARTZ
Chicago
(Replacing former Senator J. Will Howell who served the first year)

REPRESENTATIVE DAN DINNEEN
Decatur

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Chicago

REPRESENTATIVE WILLIAM ROBISON
Carlinville

BRIGADIER GENERAL CASSIUS POUST
Director, Department of Public Welfare, ex officio
Sycamore
(Replacing Rodney H. Brandon who served until May 9, 1945)

PERSONS ATTENDING THE PUBLIC HEARINGS HELD IN SPRINGFIELD, ILLINOIS

The Reverend John W. Barrett, *Chairman*, Committee on Legislation and Government Relations, Illinois Hospital Association.

Miss Pearl Bierman, *Medical Consultant*, Illinois Public Aid Commission.

Mr. Willard L. Couch, *Assistant Deputy Director*, Mental Hygiene Service, Department of Public Welfare.

Mr. Roger K. Frandsen, *Assistant Deputy Director*, Social Services, Department of Public Welfare.

Mr. Raymond M. Hilliard, *Public Aid Director*, Illinois Public Aid Commission.

Miss Anne Hinrichsen, *Informational Representative*, Illinois Public Aid Commission.

Mr. Frank W. Hoover, *President*, Illinois Hospital Association.

Miss Mary Humphrey, Board of Public Welfare Commissioners.

Miss Mary-Claire Johnson, *Administrative Assistant*, Illinois Public Aid Commission.

Mr. George J. Klupar, *Commissioner of Welfare*, City of Chicago.

Mr. Lawrence J. Linck, *Executive Director*, Illinois Commission for Handicapped Children.

Mr. Russell McKay, *President*, Illinois Convalescent and Nursing Homes Association

Mrs. Russell McKay.

Miss Edna Nicholson, *Director*, Central Service for the Chronically Ill, Chicago.

Mrs. Eleanor F. Proctor, *Chief*, Division of Standards and Services, Illinois Public Aid Commission.

Mr. Robert Rosenbluth, *Consultant*, Illinois Public Aid Commission.

Mr. Edward L. Scheibel, *President*, Illinois Association of Township Supervisors and County Commissioners.

Dr. Conrad Sommer, *Deputy Director for Mental Hygiene Service*, Department of Public Welfare.

TO THE SENATE AND HOUSE OF REPRESENTATIVES
SIXTY-FOURTH GENERAL ASSEMBLY
STATE OF ILLINOIS

The Committee to Investigate Chronic Diseases Among Indigents, which was created by the Sixty-third General Assembly, has the honor of presenting for your consideration the accompanying report of its investigations and findings.

The explorations of this Committee have uncovered one of the most serious situations which has confronted Illinois in many years. We have found that Illinois now has approximately 90,000 persons whom chronic disease has reduced to invalidism. An additional 270,000 persons are so seriously afflicted with chronic disease or permanent impairments of one kind or another that they also may require specialized services and care from time to time. Yet the facilities presently available for the care of these people are wholly inadequate, many are sub-standard, and in some sections of the State there are no facilities whatsoever.

Chronic disease has been called the "insidious modern plague." Because chronic disease incapacitates for a long period of time, it is costly and tends to place on society the burden of care for those afflicted. Medicine has become so successful in controlling the frequency and duration of acute diseases that chronic illness has now become the major cause of illness. The rapidly increasing number of older people in the population, due in part to control of acute disease, has greatly added to the prevalence of chronic disease.

The Committee has only begun to study the problem. Of particular significance in the testimony presented at the public hearings held by the Committee was the fact that sound planning for care of the chronically ill cannot be restricted to consideration of care for the indigent chronically ill. The Committee's investigations and findings have therefore been broadened to include those able to pay for their care, as well as the indigent. It is hoped that this report may be useful in making further study of the problem and in developing a public policy for the State of Illinois which will improve the facilities for the care and treatment of all persons who are afflicted with chronic illness.

The Committee wishes to express its appreciation to the many citizens and organizations who attended the hearings and aided the Committee in assembling the facts upon which this report is based. It also wishes to acknowledge the assistance given by staff members of the Department of Public Welfare and the Illinois Public Aid Commission in preparing the report.

Respectfully submitted,

THE COMMITTEE TO INVESTIGATE CHRONIC DISEASES
AMONG INDIGENTS

By Arthur J. Bidwill, *Chairman*

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NATURE OF CHRONIC DISEASE

Chronic invalids have been defined as those "persons who have been, or are likely to be, incapacitated by disease for a period of at least three months, that is, unable to follow the daily routine of the average normal person, and whose incapacity will probably continue for an indefinite period." (*The Challenge of Chronic Diseases* by Doctors Boas and Michelson).

Affliction with a chronic disease is too often considered as part of the "penalty" of growing old. Only in recent years has there been recognition of the fact that "something can be done about it" and that chronic disease is not limited to aged people but can strike children, young adults and the middle aged as well.

Actually, "Aging is a physiological and pathological, not solely a chronological process."[1]

Origin and Progress of Chronic Disease

Dr. Ernest P. Boas has described the origin and incapacitating nature of chronic diseases as follows:

> "Chronic diseases are for the most part obscure in origin, although a number of the infectious diseases, in particular, tuberculosis, syphilis, and the several forms of rheumatism are responsible for much chronic disability. Among the many diseases of unknown origin the most important are diseases of the heart, arteries, kidneys and liver, organic affections of the nervous system, mental disorders, cancer, non-tuberculous diseases of the lungs such as asthma, the various forms of rheumatism, diabetes mellitus and other disturbances of the glands of internal secretion or of metabolism.
>
> "Physical incapacity arising from these diseases is at first insignificant but gradually assumes ever greater proportions. In the earlier stages of his illness the subject of a chronic disease is ambulant and able to work, but gradually he becomes more and more disabled and eventually becomes an invalid . . ."[2]

Diseases Most Frequently Leading to Chronic Invalidism

In testimony presented before a public hearing of the Committee to Investigate Chronic Diseases Among Indigents, Miss Edna Nicholson, Director of the Central Service for the Chronically Ill of Chicago, reported concerning the diseases which most frequently lead to chronic invalidism. Miss Nicholson said:

> "Of the physical conditions responsible for invalidism, rheumatism and arthritis account for the largest single group of patients. These conditions are followed closely, in point of numbers of patients, by heart diseases. There are almost 10,000 people in Illinois who are invalids as a result of rheumatism or arthritis, and almost that many who are invalided by heart disease. These are in addition to many times these numbers of people who suffer some degree of pain and handicap as a result of these conditions

[1] *The Unseen Plague—Chronic Disease* by Doctor Ernest P. Boas, p. 50.
[2] *The Unseen Plague—Chronic Disease* by Doctor Ernest P. Boas, p. 4.

but are not completely disabled by them. Tuberculosis patients in their own homes make up the third largest group of invalids; this does not include the large numbers suffering from tuberculosis and confined to institutions.

"Arteriosclerosis and high blood pressure, including cerebral hemorrhage and resulting paralyses, account for the next largest number of invalids. These conditions are followed in frequency by diabetes; kidney disorders; cancer and other tumors; and a long list of other chronic diseases.

"Blindness, deafness, orthopedic handicaps and other physical impairments as distinguished from disease, account for another large group of partial or permanent invalids. In addition, many persons are disabled as a result of nervous and mental conditions which are not acute but which reveal 'senility,' 'forgetfulness,' and mild mental confusions."

Prevalence of Chronic Disease Among Urban Wage Earners

Important information concerning the prevalence of chronic disease among urban wage earners is given in the December 16, 1944 issue of *The Journal of the American Medical Association* which summarized the "Findings of the Study of Chronic Disease in the Eastern Health District of Baltimore."

This study indicates that 90 persons per thousand in an urban wage earning population are affected with chronic disease and that families having an afflicted member tend to require from three to four times as much medical care as other families.

These facts are significant in planning the distribution of facilities for treatment of the chronically ill. They also point to problems which will arise in planning for meeting the costs of care. For this reason the summary of the Baltimore findings, as given in *The Journal of the American Medical Association*, is quoted here in its entirety:

"The Eastern Health District of Baltimore, which comprises two city wards containing about 11,000 white families and 2,800 colored households, was chosen for a five year survey of chronic illness.[1] This was considered reasonably representative of the type of locality in which an urban wage earning population lives.

"The following chronic diseases were included: manifest mental disorders, psychoneuroses, psychopathic and personality or behavior disorders; heart disease or hypertension; arthritis; diabetes; varicose veins; gallbladder disease; peptic ulcer; chronic nephritis; cancer; rheumatic fever; tuberculosis, and syphilis. Out of each thousand persons in the population of 5 years of age and older there were 32 cases of hypertension or heart disease, 18 cases of manifest and subclinical mental disorders, 16 cases of arthritis, 7 cases of rheumatic fever, 6 cases of diabetes and 11 cases of other chronic conditions. This resulted in a total prevalence of these chronic illnesses of 90 per thousand of population.

"Families chosen because of a case of chronic disease showed an excess rate of illness among its members as compared with the other family groups. The rate of physician visits for these patients with chronic disease was 2,375 per thousand of population, or slightly more than two visits per person annually. The rate of clinic visits was 1,517 per thousand, giving a

[1]Downes, Jean.: Findings of the Study of Chronic Disease in the Eastern Health District of Baltimore, Milbank Memorial Fund Quart. 22:337 (Oct.) 1944.

total of about four visits per person annually. The same population group had an additional 2.5 visits per person for illness not related to the chronic disorder. Patients with chronic disease, therefore, had from three to four times as much medical care (measured by the number of visits from a physician!) as did the other members of their families and the general population studied. Persons in the 381 'Chronic disease families' formed 26 per cent of the total observed population, had 54 per cent of the total illnesses and received about 50 per cent of the medical care for illness given to the total population. Persons from these few families also constituted almost 40 per cent of the persons hospitalized during the second year of the morbidity study.

"This interesting report again emphasizes the necessity for sound fundamental studies of the need for and cost of medical care in differently constituted groups. A large part of the medical care problem is the control of the housing, dietary and other environmental factors which affect the development of chronic disease. From the information presented it could be deduced that any plan to spread the cost of medical care over the entire population studied would mean that a comparatively small group and one perhaps especially liable to chronic illness would receive a disproportionate share of the benefits."

Control of Chronic Disease: Role of the Family and of Industry

Dr. Herman L. Kretschmer of Chicago and President of the American Medical Association reports the intensive study now being given to "The Problem of the Chronically Ill Patient" in the April 21, 1945 issue of *The Journal of the American Medical Association*. His comments concerning prevention of chronic disease and the role to be played by the family and industry in reducing its disabling effects are pertinent to the investigations of this Committee. Dr. Kretschmer says:

"Prevention is and should be the first consideration in treatment. Prevention of chronic illness begins with health education on proper personal hygiene, right living and suitable diet, with particular emphasis placed on the importance of an annual physical examination. This often reveals foci of infection, such as infected tonsils and teeth, which can then be removed long before the arthritis or hypertension begins.

"The family has an important role in the care of the chronically ill. The patient's invalidism is too often created or increased as much by the attitude of his family and friends as by the physical condition itself. Friends and relatives in their sympathy for the patient's ill fortune may know of no other way to offer help than to shelter and overprotect the patient to the point where his spirit may develop handicaps more severe than those which cripple his body.

"We are living in an era in which many think first of institutions and of governmental aid; what burdens the individual cannot carry, Washington is asked to underwrite. The family spirit has diminished. A change of attitude must take place—that the glory of youth too will vanish and that the young person has an obligation to the other members of his family. We have become so institutionally minded for almost every kind of medical and social problem that we are apt to lose sight of the fact that a label on bricks and mortar does not mean a magical solution of the problem.

"Industry too has an important role to play in this problem. Careful consideration should be given to the aging; and effort must be made to place the older worker in a position commensurate with his capacities so that he may feel that he is taking part in production, thereby retaining his self respect. He should not be shunted off into an inconsequential position when he still is able to perform productive work.

. . . . . .

"Certainly for those patients for whom any significant degree of rehabilitation can be anticipated, active steps must be taken to restore independence and self reliance as fully and as rapidly as possible. This is of fundamental importance not only to the patient and his family but to society, and efforts must be made as fast as possible to provide the additional facilities and services needed in our communities to accomplish this.

"Management of these patients depends in part on the severity and in part on the type of illness. A certain number of them can be managed as ambulatory patients in the home, with visiting nurse and medical services. When a patient has to be hospitalized, hospitalization should be continued until he can return to his home.

"For the aged who are fairly active physically and mentally and are still continuing with their work, it has already been mentioned how their mental attitude and morale are sustained if they are given employment.

"Those who are fairly normal mentally but are physically disabled and dependent, medical service which is palliative should be given so that they may not suffer needlessly. Commitment to an institution should be deferred as long as possible, as the home accords them the happiest surroundings and their usefulness can be maintained by giving them some light duties to perform. These people, if committed to an institution, soon become helpless old men and women, because mental changes are hastened by the shifting of the environment.

"The group which needs either skilled nursing care or intensive medical treatment can be confined to a hospital designed for this purpose.

"For those who are completely helpless and permanently incapacitated, domiciliary care is all they need."

Ratio of Deaths Due to Chronic Disease

Changes which have occurred as a result of advances in medical science and public health over the last fifty years have sharply reduced the number of deaths caused by acute infectious diseases. The effect of this prolongation of the life span of the population was commented on by Miss Edna Nicholson[1] as follows:

"The almost miraculous reduction in the number of deaths caused by the acute infectious diseases—such as typhoid fever, diphtheria, smallpox, pneumonia, etc.— has meant that persons who otherwise would have died as a result of these acute conditions are, instead, living longer and are being made helpless for long periods of time preceding death by arthritis, heart disease, high blood pressure and 'strokes,' kidney disturbances, or cancer.

[1]Testimony by Miss Edna Nicholson, Director, Central Service for the Chronically Ill, Institute of Medicine of Chicago, Public Hearing held at Springfield, Illinois, April 10.

"Seventy-five years ago 14 of every 15 deaths which occurred in the United States were due to diseases which struck swiftly, and came to an end with only short periods of illness preceding death. In only one case of every 15 was death caused by a condition which brought with it a long period of invalidism preceding death. Today these so-called 'chronic' conditions account for one of every two deaths, and the full effects of the shift in the nature of diseases causing death is only beginning to be evident. The greatest advances in the control of the acute infectious diseases have come within the last 25 years—some within the last 5 or 10—and the full effect of these advances has yet to be felt."

Conclusion

Chronic disease has been described by The Surgeon General of the United States Public Health Service as "the nation's number 1 health problem." The full effect of the change in the nature of diseases causing death is only beginning to be evident. It is apparent that this change will require increased attention by the medical profession and by hospital management which have in the past given major emphasis to acute illnesses. It is also apparent that chronic disease carries with it serious social and economic implications. These will require immediate and careful study, in order that a public policy may be formulated which will keep to a minimum the economic and social losses attendant upon prolonged illness.

EXTENT OF CHRONIC ILLNESS IN ILLINOIS

According to a recent study made by the Illinois Public Aid Commission, there are at present in Illinois approximately 90,000 persons who are chronic invalids. These constitute 1.14 per cent of the population of Illinois as of the 1940 census. The Public Aid Commission's data are shown in Table I below, by age groups.

Table I. Estimated Number of Chronic Invalids in Illinois[a]

Age Groups	Total Population	Chronic Invalids	
		Per Cent of Age Group	Number
All Ages	7,898,000	1.14	90,200
Under 5	547,000	.17	900
5-14	1,161,000	.26	3,000
15-24	1,361,000	.38	5,200
25-34	1,327,000	.49	6,500
35-44	1,193,000	.94	11,200
45-54	1,055,000	1.42	15,000
55-64	686,000	2.51	17,200
65-74	400,000	4.81	19,200
75 and Over	168,000	7.20	12,000

[a]Table derived primarily from application of National Health Survey figures (Bulletin 6, 1935-1936, Appendix Table C, p. 14, "Invalids per thousand population according to age"). These figures were applied to the same age groups in Illinois, as reported in the 1940 census, and slightly modified by original studies.

While it is seen that two-thirds of the chronic invalids are under 65 years of age as against only one-third 65 or over, other studies indicate that from the standpoint of those requiring public care, approximately 60 per cent are under 65 years of age and 40 per cent are in the older group. In large part, this is due to the progressive severity of the invalidism as age increases, and further to the factor that as persons grow older, those who may have previously cared for them in the home may have died or are no longer able to provide needed care.

In developing a coordinated plan to provide for chronic invalids in Illinois, it is important to remember that only one-third of the estimated chronic invalids are 65 years of age or over. Those who are 65 or over, if indigent, may have the costs of chronic illness met through the State's Old Age Pension program. Most chronic invalids, however, are middle aged, the largest number falling within the age groups between 45 and 65 years. For this group, should indigency accompany chronic illness, facilities for meeting the costs of needed care are more restricted than they are for chronic invalids 65 years of age or over.

Persons Partially Disabled

In addition to the 90,000 persons in Illinois who are now chronic invalids, it is estimated that there are over fifteen times as many who, in varying degrees and at various times, may need some specialized services. These additional numbers represent persons who are afflicted with chronic disease or permanent impairment. The majority of these are not handicapped to the extent that they cannot take care of themselves under normal circumstances. Various estimates have been made as to the percentage of these whose handicap may become serious enough to interfere with self-care or normal adjustment in life. The Public Aid Commission study estimates that approximately 270,000 periodically may require special services or care.

Total Afflicted With Chronic Disease or Permanent Impairment

It is estimated that there are 1,483,000 persons or 18.8 per cent of the 1940 population of Illinois, who at the present time are either chronic invalids or afflicted with chronic disease or physical impairment which may lead to chronic invalidism. These are shown by age groups in Table II below.

Table II. Estimated Number of Persons in Illinois with Chronic Disease or Permanent Impairment[a]

Age Groups	Total Population	Persons with Chronic Disease or Permanent Impairment	
		Per Cent of Age Group	Number
All Ages	7,898,000	18.8[b]	1,483,000
Under 5	547,000	3.4	18,700
5-14	1,161,000	6.8	79,300
15-24	1,361,000	8.3	112,800
25-34	1,327,000	15.9	211,200
35-44	1,193,000	22.1	263,600
45-54	1,055,000	27.3	288,300
55-64	686,000	34.4	236,100
65-74	400,000	46.7	186,800
75 and Over	168,000	51.4	86,200

[a]Table derived primarily from application of National Health Survey figures (Bulletin 6, 1935-1936, Appendix Table B, p. 14, "Persons per thousand population reported to have chronic disease or permanent impairment, according to age, and for total population for the entire United States.") These figures were applied to the same groups in Illinois, as reported in the 1940 census.

[b]The National Health Survey found 17.7 per cent of the total population afflicted with chronic disease or permanent impairment but the percentages for each age grouping, when applied to the Illinois population resulted in a slightly larger overall percentage.

Table II differs from Table I in that it includes all persons afflicted by chronic disease or permanent impairment, while Table I is limited to those whose affliction is so serious that chronic invalidism exists. In comparing the two it will be noted that six per cent of the total number of sufferers have been classified as chronic invalids. In the older age groups, however, this percentage is greater.

Increasing Percentage of Aged Persons in the Total Population

The National Health Survey made during 1935-1936 found that one-half of all persons 65 years of age and over suffered from chronic diseases. This fact becomes particularly important since the percentage of older people in the total population is rapidly increasing. The National Industrial Conference Board in its "Economic Almanac" for 1943-44 estimated the increase in the aged population as follows:

Year	Population 65 and Over—Per Cent of Total Population
1940	6.8
1950	8.0
1960	10.1
1970	11.9
1980	14.4

While it is true that all old people are not sick, the largest number of chronic invalids being middle aged, it is the older group of chronically ill persons who particularly need facilities for care outside their own homes. Children and young adults who are chronically ill more frequently remain in their own homes. As age increases, the possibility of care in the home decreases. Parents and other members of the family who have been caring for the invalid grow old and become unable to continue care of the patient. Although a little more than one-third of all chronic invalids are 65 years of age and over, about one-half of all invalids needing care outside their own homes are over 65.

Extent of Indigency Among Chronic Invalids

An estimate of the extent of indigency among chronic invalids in Illinois was given by Miss Edna Nicholson of the Chicago Central Service for the Chronically Ill. In her report before the Public Hearing in Springfield on April 10, 1945 Miss Nicholson said:

> "For purposes of planning facilities for care of the chronically ill in Illinois, it can safely be estimated that there are 25,000 to 30,000 invalids in the state who are now in need of some financial help in meeting the costs of adequate care, or will be within the immediate future; and that if there should be a sharp decline in employment and wages this number would be considerably increased.
>
> "This does not mean that institutional facilities must be provided for all of these persons. About a half—possibly as many as two-thirds of them—can, and will prefer to, remain with their families in their own homes. For many of these old age pensions will provide the only help they need. For others, help may be provided through other forms of public assistance, or to some extent through private philanthropy.
>
> "There are about 10,000 to 15,000 invalids, however, who are indigent and who cannot be cared for in their own homes, either because they have no homes and families or because the necessary arrangements for their care cannot be made in their homes. To this group should be added at least 20,000 more invalids who also need care outside of their own homes but who are able to pay for their care from their own or their families' resources. For these persons homes offering personal care and nursing services must be made available.

"To summarize: conservative estimates indicate that, in addition to care provided for invalids by their families in their own homes, facilities are needed in nursing homes and institutions for the care of 35,000 to 40,000 invalids in Illinois, of whom about 25,000 are already in need of financial assistance or will be as soon as the present high levels of employment and wages begin to decline."

Chronic Invalidism Among Public Aid Recipients

The percentage of chronic invalidism among those currently receiving public aid is estimated to be 87 per cent greater than it is among those earning over $1,000 a year. This is readily understandable since the factor of chronic illness has often produced or contributed largely to the need for public aid.

Among Old Age Pension recipients it is estimated that there are 7,000 chronic invalids.

There is no exact information as to the number of chronic invalids on the present poor relief rolls in Illinois. However, the majority of the 52,949 persons who were receiving relief in May 1945 were classified as unemployable. In this group will be found many middle-aged persons afflicted with chronic disease or suffering from physical impairment.

Of the persons at present residing in county homes in the State, it is estimated that 80 per cent are in need of continuing nursing service and care.

Conclusion

All of the factors enumerated above point to the increasing seriousness of the problem of chronic illness. They indicate that chronic invalidism is not confined to the aged or to any one group alone; nor is it confined to the indigent. While the problem of chronic illness bears more heavily on the poor than on others, it is important to keep in mind the fact that the indigent chronically ill constitute only one part of a very large group of invalids in Illinois, all of whom are urgently in need of more and better facilities for care.

FACILITIES CURRENTLY AVAILABLE IN ILLINOIS FOR CARE OF THE CHRONICALLY ILL

As brought out in the previous section of this report, testimony presented to this Committee indicates that Illinois now has approximately 90,000 chronic invalids and an estimated 270,000 additional persons so seriously afflicted with chronic disease or physical impairment that they also may require from time to time hospital or nursing service more extensive than that which can be provided by relatives or friends at home.

At the present time there is no complete census concerning the number and bed capacity of hospitals, sanataria, nursing homes, or other institutions in Illinois which offer facilities for care of the sick and, in particular, for the chronically ill or physically impaired who require care outside of their own homes. The fact that the present laws of Illinois do not require licensing of hospitals and related institutions makes unavailable at a central point in the State complete information concerning hospital and nursing facilities. The partial information available, however, would indicate that existing facilities are both insufficient and so unequally distributed as to present a serious problem in providing care to all ill persons who need access to them, especially the chronically ill.

Types of Facilities

Facilities currently available for care of the chronically ill are of the following types:

HOSPITALS AND RELATED INSTITUTIONS.

- Federal Hospitals (for Veterans).
- State Hospitals (for the Mentally Ill).
- State Schools and Institutions (for the Blind, the Deaf and Mentally Defective).
- State Hospitals for Special Types of Illness (Venereal Disease, Eye and Ear).
- General Hospitals (Mainly Restricted to the Acutely Ill).
- Tuberculosis Sanitaria.
- County Homes and Infirmaries.
- Homes for the Aged.
- Nursing Homes and Homes for Convalescent Care.
- Boarding Homes.

HOME NURSING AND HOUSEKEEPING SERVICES.

In a few communities hospital and institutional facilities are supplemented by visiting nurse services and housekeeping services which provide nursing or housekeeping services to the chronically ill who remain in their own homes. The best available information indicates that housekeeping service is available only in the City of Chicago where it is provided by the Chicago Home for the Friendless, by the Jewish Social Service Bureau, and by the Chicago Welfare Administration.

The Visiting Nurse Association has established services in only 21 communities, those chiefly metropolitan centers. Information available to the

Illinois Public Aid Commission three years ago indicated that the Visiting Nurse Association had as of that time services in Alton, Aurora, Chicago, Danville, Decatur, East Moline, East St. Louis, Elgin, Evanston, Galesburg, Joliet, Kewanee, LaSalle, Marseilles, Moline, Ottawa, Peoria, Quincy, Rockford, Rock Island and Springfield.

Hospitals and Related Institutions[1] Registered with The American Medical Association

Although by no means restricted to the chronically ill nor, on the other hand, indicative of the total number of facilities available in Illinois for care of the sick, information collected by the American Medical Association for the year ending September 30, 1944 concerning hospitals and related institutions registered with that Association points to the inadequacy of existing facilities for hospital and nursing care, both in terms of bed capacity and distribution so as to provide ready access to patients throughout the State.

Obviously, all of the beds in the hospitals or related institutions registered with the American Medical Association are not available to the chronically ill. It may be assumed for example, that most of the beds in the hospitals classified as general hospitals are reserved for the acutely ill. Furthermore, seventeen of these hospitals are operated by the Federal Government for the benefit of servicemen or veterans only. Others are operated by county or city governmental units and admission is in general restricted to the indigent.

Information concerning the 327 hospital facilities registered with The American Medical Association is shown in Tables III and IV on the following pages. Table III classifies these facilities by type of service; Table IV classifies them by type of control.

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[1]The term "related institution," as used by the American Medical Association, means "infirmaries, nursing homes, and other institutions designed to give certain medical and nursing care in an ethical and acceptable manner, without giving a full hospital service." (*The Journal of the American Medical Association*, March 31, 1945, p. 786.)

Table III. Registered Hospital Facilities in Illinois During 1944, By Type of Management[a]

Type of Service	Number of Hospitals	Number of Beds	Average Occupancy	Per Cent Occupancy
ALL TYPES	327	101,342	81,774	80.7
General[b]	218	44,701	31,052	69.5
Nervous and Mental	30	45,799	42,980	93.8
Tuberculosis[c]	32	4,360	3,425	78.6
Maternity	6	574	326	56.8
Industrial	2	85	44	51.8
Eye, Ear, Nose, Throat[d]	2	225	108	48.0
Children's	3	382	203	53.1
Orthopedic	4	220	121	55.0
Isolation	2	456	62	13.6
Convalescent and Rest[e]	14	564	361	64.0
Hospital Departments of Institutions	12	3,506	2,689	76.7
All Other Hospitals	2	470	403	84.1

[a]Data for Illinois assembled by the Illinois Public Aid Commission from article entitled "Hospital Service in the United States" published in the March 31, 1945 issue of *The Journal of the American Medical Association*. Above figures are from pages 776-778. Data are limited to hospitals and related institutions registered by the American Medical Association according to standards adopted by that Association. All Illinois hospitals and related institutions are not registered. Data were reported for the 12 months ended September 30, 1944.

[b]Approximately 50 of these general hospitals, or 23 per cent, are located in Chicago and Cook County.

[c]These tuberculosis sanitaria were distributed among 24 counties, concentrating in the northern and central portions of the State. There are only three registered tuberculosis sanitaria in the southern part of the State. Twenty of the sanitaria are operated by county governments; three by city governments; one by city and county together; one by the Veteran's Administration; and the remainder by non-profit associations.

[d]Both of these are in Chicago.

[e]All but two of these are in Cook County.

Table IV. Registered Hospital Facilities in Illinois During 1944, By Type of Management[a]

Type of Control	Number of Hospitals	Number of Beds	Average Occupancy	Per Cent Occupancy
ALL TYPES	327	101,342	81,774	80.7
GOVERNMENTAL	88	74,893	61,283	81.8
1. Federal	17	19,341	11,987	62.0
2. State	22	43,760	40,660	92.9
3. County	27	8,313	6,222	74.8
4. City	21	3,355	2,312	68.9
5. City-County	1	124	102	82.3
NON-PROFIT	191	24,224	18,928	78.1
1. Church Related	89	13,065	10,457	80.0
2. Non-Profit Ass'n	102	11,159	8,471	75.9
PROPRIETARY	48	2,225	1,563	70.2
1. Individual and Partnership	33	980	669	68.3
2. Corporation	15	1,245	894	71.8

[a]Data for Illinois assembled by Illinois Public Aid Commission from article entitled "Hospital Service in the United States" published in the March 31, 1945 issue of *The Journal of the American Medical Association*. Above figures are from pages 774-776. See Table III, footnote "a" concerning limitations of these data.

Hospitals Not Registered with The American Medical Association

Complete information is not available as to the number of hospitals established in Illinois but not registered with the American Medical Association. The only information available is that known to the Illinois Public Aid Commission concerning non-registered hospitals giving care to public aid recipients.

As of May 1945, there were 15 such hospitals outside of Cook County, exclusive of non-registered infirmaries in County Homes. No information is available concerning the bed capacity and average occupancy of these 15 non-registered hospitals.

No information is available concerning non-registered hospitals in the City of Chicago. Comparing the number of registered hospitals with those listed in the classified telephone directory, it may be estimated that there are at least 15 non-registered hospitals in the City of Chicago.

Non-Registered Nursing Homes and Homes for Convalescent Care

Complete information for this type of facility is likewise not available, except for information in possession of the Public Aid Commission concerning such homes willing to give care to public aid recipients at rates agreed upon between the homes and the Commission.

As of March 1945 the Public Aid Commission authorized nursing home care for public aid recipients in 163 convalescent and nursing homes, of which only seven were registered with the American Medical Association.

The distribution of these homes between Cook County and counties other than

Cook and by the usual monthly rate charged for a bed patient is shown in the following table:

Table V. Number of Nursing Homes in Illinois Admitting Patients from Public Aid Rolls as of March 1945, Distributed According to Usual Monthly Rate for Bed Patient[a]

	Total Number of Homes	Number of Homes, by Usual Monthly Rate for Bed Patient[b]				
		Lower than $40 or $40-$60	$61-$79	$80-$89	$90-$99	$100 or Over
TOTAL STATE	163[c]	64	31	13	23	32
Cook County	84	19	20	7	17	21
Other Counties	79[d]	45	11	6	6	11

[a]Table prepared by the Illinois Public Aid Commission.

[b]In accordance with a policy adopted in September 1944, the Commission pays a maximum of $60 per month for bed patients; $50 to $59 per month for semi-ambulant patients; and $40 to $49 per month for ambulant patients. Homes included in this table which charge in excess of $60 per month for bed patients are, however, caring for ambulant or semi-ambulant patients at Commission rates. In a few instances, they have accepted bed patients at the Commission rate, although their usual monthly rate is higher.

[c]Exact information concerning the bed capacity of these homes is not available but it is estimated that they contain approximately 3,500 beds, 1,400 in Cook County and 2,100 in the other counties. The long waiting lists indicated that occupancy is 100 per cent.

[d]Fifty-one of the counties outside of Cook have no nursing homes admitting public aid recipients. In 29 of these counties there is only one nursing home which will admit public aid recipients.

Private Homes for the Aged[1]

Since chronic illness tends to afflict the middle-aged and the aged more frequently than children and adults, homes for the aged represent an important potential resource in planning for care of the chronically ill who cannot be cared for in their own homes.

There are about 80 private institutions for the aged in the State. These homes are supported by fraternal, religious, or national groups. Of these, 49 have admitted public aid recipients for care. Information is available only for the 49 which have admitted public aid recipients. This is summarized on the following page.

[1]The information given here represents a summary of a report of May 4, 1945 of the Illinois Public Aid Commission entitled "Private Institutional Policy—Chronic Care."

Table VI. Private Institutions for the Aged in Illinois Admitting Public Aid Recipients, as of May 1945

	Number of Institutions	Number Now Having Chronic Care Facilities	Range of Average Number of Residents
TOTAL STATE	49	8	6 to 263
Cook County	21	5	10 to 263[a]
Other Counties	28	3	6 to 146[b]

[a]The smallest is the Home for Aged Colored People; the largest, the Chicago Home for Incurables.

[b]The smallest is Jacob's Home in Lee County; the largest, St. Vincent's Home in Adams County. The homes in counties other than Cook are distributed among 22 counties.

There is a growing trend among these institutions toward the development of facilities for caring for chronically ill persons. The Chicago Home for Incurables has always cared for chronic patients. Such facilities have more recently been developed by the Home for Aged Jews, the Orthodox Jewish Home, Rosary Hill Convalescent Home, and St. Ann's Home in Cook County and by St. Joseph's Hospital in Adams County, the I.O.O.F. Home in Coles County and the Eastern Star Sanitorium in Macon County.

It is expected that such facilities will be developed in more of the institutions of this type as the problem of the chronically ill receives increasing attention and as equitable bases of payment for care in such institutions are developed in coordination with payment rates for other types of facilities.

Boarding Homes

No information is available concerning the number of such homes in the State which include among their residents many of the less serious cases of chronic illness. In the opinion of the Illinois Public Aid Commission, many of the homes now designated as "nursing homes" are really only boarding homes. In the absence of state licensing provisions proper classification cannot be made.

County Homes and Infirmaries

Before the full problem of chronic disease and chronic invalidism came to be recognized, many assumed that public aid in its modern form, especially Old Age Pensions and other types of "social security," would completely depopulate the traditional "county poor farms" and remove all reasons for their continued maintenance.

It has therefore been a matter of much surprise to many when they have realized that county homes and infirmaries continue to operate in Illinois, that they have been depopulated but not completely depopulated, and that in many areas of the State they represent the only facility for chronic invalids, especially older people who have developed peculiarities or irritabilities which make adjustment elsewhere difficult. Furthermore, in a number of instances, these county homes have been found to offer nursing services far superior to those offered in neighboring unlicensed and unsupervised "private nursing homes."

As of March 1945, there were 72 county homes in operation in Illinois. Many

counties had discontinued operation of such homes during the years following 1935 when Illinois enacted its first Old Age Pension Act.

While it is true that there is no use for the old type "poor house" under present day conditions, the existing 72 county homes still in operation represent a potential resource for care of the chronically ill. Information concerning these 72 county homes is given in the table below.

Table VII. Potential Facilities for Care of the Chronically Ill Represented by County Homes in Operation in Illinois as of March 1945[a]

County	Capacity	Number of Inmates as of November 25, 1944	Per Cent Occupancy November 1944
ALL COUNTIES	7,264	4,303	59.2
Adams	75	32	42.7
Brown	15	3	20.0
Bureau	100	42	42.0
Calhoun	25	3	12.0
Carroll	31	26	83.9
Cass	18	8	44.4
Champaign[b]	100	41	41.0
Clark	13	4	30.8
Coles	40	20	50.0
Cook—(Infirmary only)[b]	2,780	2,239	80.5
Crawford	30	7	23.3
De Kalb	80	47	58.8
De Witt	30	12	40.0
Douglas[c]			
Du Page	47	47	100.0
Edgar	20	2	10.0
Edwards	12	1	8.3
Effingham	24	1	4.2
Fayette	25	13	52.0
Ford	35	11	31.4
Franklin	21	12	57.1
Fulton	60	32	53.3
Greene	20	7	35.0
Hamilton	8	6	75.0
Hancock	40	28	70.0
Henderson	20	2	10.0
Henry	80	20	25.0
Iroquois	60	16	26.7
Jackson	15	6	40.0
Jersey	25	3	12.0

(Continued on Following Page)

Table VII. Potential Facilities for Care of the Chronically Ill Represented by County Homes in Operation in Illinois as of March 1945[a]

(Continued from Preceding Page)

County	Capacity	Number of Inmates as of November 25, 1944	Per Cent Occupancy November, 1944
Jo Daviess	10	2	20.0
Kane	190	127	66.8
Kankakee	60	21	35.0
Knox	100	39	39.0
Lake[a]	90	66	73.3
La Salle	275	130	47.3
Lawrence	50	3	6.0
Lee	49	25	51.0
Livingston	70	39	55.7
Logan	40	6	15.0
McDonough	60	11	18.3
McHenry	85	60	70.6
McLean	120	40	33.3
Macon	100	60	60.0
Macoupin	68	28	41.2
Madison	130	97	74.6
Menard	26	26	100.0
Mercer	40	15	37.5
Monroe	30	23	76.7
Montgomery	25	12	48.0
Morgan	76	10	13.2
Moultrie	15	9	60.0
Ogle	53	36	67.9
Peoria	270	82	30.4
Piatt	50	8	16.0
Putnam	15	2	13.3
Randolph	25	9	36.0
Rock Island	80	38	47.5
St. Clair[b]	300	159	53.0
Saline	16	5	31.3
Schuyler	30	7	23.3
Scott	25	3	12.0
Shelby	25	6	24.0
Stephenson	90	25	27.8
Vermilion	137	100	73.0

(Continued on Following Page)

Table VII. Potential Facilities for Care of the Chronically Ill Represented by County Homes in Operation in Illinois as of March 1945[a]

(Continued from Preceding Page)

County	Capacity	Number of Inmates as of November 25, 1944	Per Cent Occupancy November 1944
Warren	100	23	23.0
Wayne	14	5	35.7
White	100	8	8.0
Whiteside	65	25	38.5
Will	91	90	98.9
Williamson	12	9	75.0
Winnebago[b]	176	114	64.8
Woodford	32	9	28.1

[a]Table derived from Illinois Public Aid Commission report entitled "The Status of County Homes in Illinois as of November 25, 1944," adjusted to exclude County Homes which were discontinued after November 1944.

[b]The hospital facilities of these four county homes are registered by the American Medical Association.

[c]The Douglas County Home was discontinued March 1, 1945 and leased to an individual as a grain farm. It had a capacity of 21 inmates. In November 1944, it had three inmates in residence. Douglas County, however, maintains a hospital separate from the County Home. This hospital with a capacity of 40 and an average occupancy of 27 is registered by the American Medical Association.

[d]The Lake County General Hospital is maintained separately from the Lake County Home. The Lake County General Hospital is registered by the American Medical Association.

In an earlier study made by the Illinois Public Aid Commission in March 1944, when 83 county homes were in operation, the following estimate was made of their adaptability for conversion into homes for care of the chronically ill:

27 Adaptable with minor renovation.

23 Adaptable with substantial renovation. (County homes in this group are of masonry construction and are equipped with plumbing and central heating, but floor layouts and other features of design may require modification to provide suitable facilities for the care of the chronically ill).

30 Not adaptable.

3 Available information does not justify opinion as to adaptability.

83 Total

Conclusion

The information given above concerning facilities currently available in Illinois for care of the chronically ill would indicate that future study should be directed toward the following possibilities for establishing additional facilities for the chronically ill and for co-ordinating all types of facilities so as to assure adequate care and service to all residents of the State of Illinois who are afflicted with chronic disease or permanent impairment:

1. The possibility of setting aside more beds in general hospitals for patients who are chronically ill, or of establishing infirmary facilities in connection with general hospitals.

2. The possibility of converting County Homes which can be so converted into homes for the infirm and chronically ill, with proper regard to construction, sanitation, and general hygiene so as to safeguard the health, safety, and comfort of the patients.[1]

3. The possibility of establishing additional tuberculosis sanataria, with attention to their proper distribution so as to provide ready access to tubercular patients in all parts of the State.[2]

4. The possibility of establishing additional infirmary facilities in private institutions for the aged.

5. The possibility of establishing additional private nursing homes and homes for convalescent care, under competent management and with proper standards, licensed, and supervised by a state agency or by local governments in conformity with state standards.[3]

6. The possibility of establishing additional home nursing and housekeeping services.

The need for continued study of the problem of the chronically ill is obvious. This should be accomplished through extension of the present legislative Committee, enlarged so as to include, ex officio, representatives of all State agencies directly concerned with the problem.[4]

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[1]This recommendation has already been acted on by the Sixty-fourth General Assembly which passed the Rennick-Laughlin Bills, Senate Bills 210, 212, 213, and 534. These Bills have been signed by Governor Dwight H. Green. The importance of these Bills as representing a major step in developing facilities for the chronically ill, is discussed in a later section of this report.

[2]Senate Bills 47 and 48, House Bill 325, and House Joint Resolution 29 of the Sixty-fourth General Assembly have reference to care for the tubercular.

[3]This recommendation has already been acted upon by the Sixty-fourth General Assembly which has under consideration three bills pertaining to the licensing of hospitals, nursing homes, and related institutions. These Bills are Senate Bill 373 and House Bills 252 and 103. Senate Bill 373 is the most comprehensive of the three Bills. These Bills are discussed in more detail in a later section of this report.

[4]The Sixty-fourth General Assembly has before it for consideration Senate Bill 436 which would accomplish this recommendation with specific reference to the chronically ill. It also has before it for consideration Senate Bill 336, which pertains to the more general subject of the hospitalization and medical needs of the State. Both of these Bills are discussed in a later section of this report.

STAGES IN RECOGNITION OF THE PROBLEM AS ONE REQUIRING JOINT STATE AND COMMUNITY PLANNING

Action Prior to 1900: State Institutions for Special Groups

In Illinois, as elsewhere, the first chronic illness to receive recognition as requiring special action by the State as well as local communities was that of mental illness and mental defect. Provision was made for care of such persons in State hospitals for the mentally ill, of which there are now eleven,[1] and the two institution-schools for the mentally defective at Dixon and Lincoln.

For the blind, a school was established at Jacksonville (1849) and an Industrial Home in Chicago (1887). A school for the deaf was established at Jacksonville (1839).

Non-Institutional Care Prior to 1900

Early indication that action by the State would not be limited to the operation of state institutions for those requiring custodial care, is found in the "Act to regulate the state charitable institutions," etc., approved April 15, 1875. This Act included provision for a "charitable Eye and Ear Infirmary." The object of this infirmary was defined as that of providing "gratuitous board and medical and surgical treatment for all indigent residents of Illinois, who are afflicted with the diseases of the eye or ear."[2] The name of this infirmary, which is located in Chicago, was changed by the General Assembly in 1923 to "The Illinois Eye and Ear Infirmary" and admission to its facilities was no longer limited to those "of absolute inability to pay charges for board or treatment."[3]

Development of State Facilities: 1900-1943

Legislation having a bearing on specific aspects of chronic disease or physical impairment enacted by the General Assembly of Illinois between 1900 and 1943 is listed below, in chronological order:

1911—Visitation and Instruction of the Adult Blind (June 7, 1911).
Surgical Institute for Children (June 6, 1911).

1913—Colony for Epileptics (May 27, 1913).

1919—Rehabilitation of Physically Handicapped Persons (June 28, 1919).
Segregation and Treatment of Diseased Persons (June 28, 1919).

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[1]Counting the Illinois Security Hospital at Menard (for the insane convicted of crimes) and the Veterans Rehabilitation Center established in Chicago in 1944. The nine basic state hospitals for the mentally ill are located at Alton, Anna, Dunning, East Moline, Elgin, Jacksonville, Kankakee. Manteno and Peoria.

[2]*Illinois Revised Statutes 1943*, Ch. 23, Par. 44.

[3]*Ibid.*, Ch. 23, Pars. 70a and 71.

1921—Rehabilitation of Injured Persons (June 28, 1921). The title of this act was amended June 16, 1943 to "An Act in relation to vocational rehabilitation of disabled persons."

1931—Illinois Research and Educational Hospitals (July 3, 1931)[a].

1933—Physically Handicapped Children (June 30, 1933).

1937—Tuberculosis Sanitarium Districts (May 21, 1937).

1941—Committee to Investigate Chronic Diseases Among Indigents (July 17, 1941).

1943—Cancer and Tumor Relief (May 12, 1943).
Committee to Investigate Chronic Diseases Among Indigents (July 22, 1943).

Recognition of the Problem in its Entirety

The first recognition of the problem of chronic illness in its entirety, came with the establishment of the legislative committees in 1941 and 1943. The 1941 committee was hampered in its work by the impact of the war on all activities in the State. It was therefore continued in 1943 by Act (S.B. 551) of the Sixty-third General Assembly.

The duties of the present committee were defined as follows in the Act creating it:

"The Committee shall have the following duties:

1. To make a complete and thorough survey of the number of persons in Illinois in indigent circumstances who are afflicted with chronic diseases not already provided for in existing State institutions, and who require hospital care at public expense.

2. To determine and recommend the location or locations for institutions to administer to such persons, which are best suited to adequately and efficiently administer to and care for such persons.

3. To prepare and submit estimates of the cost of any proposed construction of such institutions, of the cost of adequate equipment, and of the annual cost of maintenance.

4. To draw, or cause to be drawn, a bill for introduction in the Sixty-fourth General Assembly, to provide for the construction, equipment, and operation of such institution or institutions as the Committee determines to be necessary.

All findings, determinations, and recommendations of the Committee shall be reported to the Sixty-fourth General Assembly at the same time that the bill drawn by the Committee is introduced, and thereupon the Committee shall cease to exist."

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[a]The building of the Illinois Research Hospital was authorized in 1925 in an appropriation to the Department of Public Welfare. The Act of 1931 made the Department of Public Welfare and the University of Illinois jointly responsible for management and control, with the Department generally responsible for administration and the University for research, educational and professional activities.

It will be noted that the General Assembly planned that the Committee restrict itself to the *indigent* among the chronically ill and directed that it focus its study on the feasibility of establishing *state* institutions for such persons.

Testimony presented at all of the hearings of the Committee has emphasized that sound planning for care of the chronically ill could not be arrived at by restricting inquiry to the indigent (see pages 8-9 of this report). The Committee has, therefore, extended its inquiry into chronic illness and physical impairment as it affects the entire population of the State of Illinois, without regard to their ability to pay for care.

Two factors have caused the Committee not to limit its inquiry to the feasibility of establishing state institutions for the care of the chronically ill. The first and obvious factor has been the unavailability of building material under present war-time conditions. Second, and probably more important from the long-time view, is the costliness of such institutions and their general undesirability for the morale and rehabilitative potentialities of the majority of chronically ill persons.

The Committee has found medical opinion and the opinion of experts in the field of public aid and public welfare unanimous in the view that institutionalization, especially state institutionalization, should be looked upon as the last resort in planning for care of the chronically ill. The opinion of Dr. Herman L. Kretschmer, President of the American Medical Association, in this regard has been quoted on pages 3 and 4 of the present report. In the same article Dr. Kretschmer had this further comment:

> "Whether or not the chronically ill should be hospitalized in institutions dedicated to that purpose or whether they should be housed in wings built as additions to our present hospitals for acute diseases is a subject still under debate. Some believe that they should be cared for in the separate wings of the so-called acute hospitals and others believe that special hospitals should be built for that particular purpose.
>
> "In planning for extension of institutions or hospitals for the future, we should bear in mind the fact that prevention may reduce the number of cases that will require institutional care and that such extensive expansion might not be necessary."[1]

In testimony given in the Committee's public hearing in Springfield on April 25, 1945, Mr. Rodney H. Brandon, former Director of the Department of Public Welfare, said:

> "Establishment of state institutions for the chronically ill will create a new group of state charges. It will also segregate the ill from their home communities where they have personal ties and thus contribute to the depressing nature of chronic illness."

Conversion of County Homes into Facilities for the Chronically Ill: The Rennick-Laughlin Bills, 1945

During recent years, County Boards of Supervisors or Commissioners, in those counties which have maintained county homes and infirmaries, have become concerned with the problem. With the State's Old Age Pension and Blind Assistance Acts depleting the number of able-bodied persons residing in these institutions,

[1] *The Journal of the American Medical Association*, April 21, 1945, p. 1026.

interest has developed in modernizing the physical plants of these institutions so as to convert them into county-maintained nursing homes and infirmaries for the chronically ill. As instances of this movement, the Henry County Home at Kewanee and the Du Page County Convalescent Home in Wheaton may be cited.

Other counties, faced with the depopulation of the county homes as a result of the Old Age Pension and Blind Assistance Acts, have discontinued to operate such homes and have either closed them down or rented them out for operation as private nursing homes. Sangamon and Grundy counties may be cited as examples of this type of action.

As a result of a broadened policy announced by the Illinois Public Aid Commission in the Fall of 1944, which made available to Old Age Pension and Blind Assistance recipients aid in excess of $40 per month to purchase care in nursing homes, county governments having plants which were convertible to suitable nursing homes or infirmaries have taken active interest in bringing about amendments to the Illinois law which would enable them to develop these county plants into desirable local facilities for care of the chronically ill. County officials, in cooperation with the Public Aid Commission and the General Assembly have brought about action in this regard through Senate Bills 210, 212, 213 and 534, sponsored by Senators Rennick and Laughlin.

These Bills, which have now been passed by the Sixty-fourth General Assembly and signed by the Governor, represent one of the most important acts taken by the General Assembly of Illinois to provide decent facilities for care of the chronically ill in their home communities. This is accomplished by the following provisions of the Rennick-Laughlin Bills:

1. Old Age Pension recipients who need institutional care will be permitted to retain their status as Old Age Pension recipients if they reside in a County Home, provided the facilities for such Home with respect to its construction, sanitation, and general hygiene are in conformity with standards prescribed by the Illinois Public Aid Commission for safeguarding the health, safety, and comfort of the inmates and patients of such Home. (S.B. 210).

2. Blind Assistance recipients who need institutional care will be permitted to retain their status as Blind Assistance recipients if they reside in County Homes, provided such Homes meet standards prescribed by the Public Aid Commission. (S.B. 534).

3. The "Act to provide for the establishment and maintenance of county poor houses" has been renamed "An Act in relation to the establishment, maintenance, and operation of county homes for persons who are destitute, infirm, or chronically ill, or who are able to pay for their care and maintenance therein; and to authorize the care and maintenance of needy residents in county homes of other counties." (S.B. 212). This Bill is an important milestone in modernizing public facilities for the indigent ill and those with borderline income. All references to the out-of-date "poor houses" are stricken from the Act. The nature of these homes, which has in fact changed over the years, is thus recognized and the "pauper stigma" removed. It is also significant that Senate Bill 212 provides that any resident of the county who desires to

purchase care and maintenance in a county home with his own funds, may do so.

4. The Pauper Law is revised to delete all references to "poor houses." Instead, there is substituted the term "county homes for the destitute, infirm, or chronically ill." (S.B. 213).

   This Bill, together with S.B. 212, removes all language in existing Acts pertaining to County Homes which implied that residents of such Homes were necessarily "paupers."

Chicago's Central Service for the Chronically Ill

Interest in the problem as one demanding community-wide planning was manifest in the City of Chicago where the Central Service for the Chronically Ill was organized in January 1944, under the auspices of the Council of Social Agencies and later taken over by the Institute of Medicine. The purpose of this organization is to study the need for facilities for chronic care in the Chicago metropolitan area, to establish a central registry for such facilities, and to stimulate and help in their development.

The Administrative Committee of the Central Service for the Chronically Ill, under the able Chairmanship of Dr. William F. Petersen, has given leadership in exploring the problem and in organizing community facilities to meet the need. Extensive surveys of the problem and of varying types of facilities have been made. The Central Service for the Chronically Ill, through its Director, Miss Edna Nicholson, has made its findings and recommendations available to this Committee.

Development of Facilities in Homes for the Aged

Homes for the aged maintained by religious and charitable organizations have always been interested in the problem of the chronically ill since many of their residents are afflicted with chronic illness. Many of these homes have developed extensive facilities for caring for the chronically ill among their residents.

Illinois Convalescent and Nursing Homes Association

Privately operated nursing homes and convalescent homes have also been interested in the problem. The Illinois Convalescent and Nursing Homes Association, through its President, Mr. Russell McKay, has cooperated with the Committee in making its investigations.

Regulation of Nursing Homes

Wide public interest has been developed during recent years in improving the standards and facilities of nursing and convalescent homes operated for profit. Out of this interest, there has developed a recognition of the need for licensing and supervision by a state agency and for developing resources whereby indigent persons needing care in such privately operated institutions might have the costs of their care met through public funds in such amounts to enable the operators to maintain adequate standards of safety, sanitation, and service.

This aspect of care for the chronically ill has resulted in the introduction of several bills in the present General Assembly which propose to license hospitals, nursing homes, and other institutions giving care to the sick, including those afflicted with chronic illness. These bills are discussed in the last section of this report.

FACTORS REQUIRING PARTICULAR STUDY IN CONNECTION WITH PLANNING FUTURE ACTION

The urgency of the need for more and better facilities for the care of the chronically ill, and the prospect that this need will steadily increase in the future, are so great that action must be taken as rapidly as possible. It is important, however, that action be based upon sound planning. The organization of the necessary facilities will be a complicated administrative problem and the provision of adequate care for the large numbers of people needing it will entail significant expenditure of funds. Full consideration of the varied aspects of the problem and careful planning are therefore essential if an effective and economically sound program is to be established.

Particular study must be given to (1) the type of facilities needed to achieve maximum rehabilitation of patients; (2) proper location and coordination of facilities; and (3) methods of financing care for indigent persons.

Types of Facilities Needed to Achieve Maximum Rehabilitation of Patients

In testimony before the Committee in the public hearing at Springfield, April 10, 1945, Miss Edna Nicholson, Director of the Central Service for the Chronically Ill, Chicago, stated:

> "Two quite different but supplementary types of facilities are needed for adequate care of chronically sick people:
>
> (a) *Facilities and services for diagnosis and treatment* by competent physicians making use of good hospital facilities; and
>
> (b) *Homes* for people who do not have homes of their own in which care can be provided, and who do not need diagnosis or active treatment in a hospital but do need some personal care and nursing services during the months or years through which they must live with their disabilities.
>
> "Although homes should be distinguished from hospitals in planning for the care of the chronically ill the mistake should not be made of assuming that medical services are not important in the homes. Careful study by competent medical authorities should be a part of the admission procedure in every home in order to assure that all possible efforts have been made to cure or relieve the conditions which are disabling the patient before accepting his condition as permanent and hopeless. Provision must also be made for continuing supervision by competent physicians of care given patients in the home and for periodic re-examination of the patient as changes in his condition may occur. It has been pointed out by authorities on the subject that one of the most tragic aspects of the care which has been available in many county infirmaries in the past has been the lack of good medical service of this kind, and the extent to which, once admitted

to the infirmary, people have been left to live out their lives in invalidism—a burden to themselves and to society—when better medical services might have cured or greatly relieved their disabilities."

Proper Location and Coordination of Facilities

In this same hearing, Miss Nicholson also summarized problems pertaining to the proper location and coordination of facilities for the chronically ill. Miss Nicholson said:

"Thought will be needed on such questions as:

Medical services: The best methods for assuring competent medical services for diagnosis, treatment, and continuing medical supervision; the relationships which should exist between medical services in homes and hospitals; the relationships which should obtain between these medical services and those available to other patients in the community.

Care for indigent persons: The relative advantages and disadvantages of establishing and maintaining special homes and hospitals offering "free care" to the indigent, as distinguished from the advantages and disadvantages of permitting indigent patients to receive their care in the same homes and hospitals as serve other persons in the community; etc.

Advisability of specialization: The relative merits of establishing special hospitals for the chronically ill apart from hospitals already in existence. (Many of the facilities and types of equipment needed in diagnosing and treating persons suffering from chronic illness are identical with those needed by patients suffering from any other illness, and there is increasing opinion among physicians and hospital administrators that establishing separate hospitals for diagnosis and treatment of chronically ill patients leads to unnecessary duplication of expense and administrative complications.) Thought should be given also to the advisability of establishing specialized hospitals for the various diagnostic groups, i.e. a cancer hospital; a cardiac hospital; an arthritis hospital; a hospital for kidney disorders; etc. Here, also, opinion is increasing among persons familiar with the problems that generalized institutions, perhaps with specialized wards or units, are preferable to specialized institutions.

"The practical questions outlined above, and many others, will need careful thought as a preliminary to definite action if an effective and economically sound program is to be established in Illinois."

Methods of Financing Care for Indigent Persons

Miss Nicholson's testimony just quoted included reference to the problem of financing care for the indigent among the chronically ill.

In testimony before a subsequent public hearing on April 25, 1945, Raymond M. Hilliard, Public Aid Director, Illinois Public Aid Commission, discussed the possibility of extending the authority and financial responsibility of the State with respect to aiding townships and other local governmental units in meeting the costs of the indigent chronically ill.

One possibility mentioned by Mr. Hilliard was that of amending the powers given the Public Aid Commission so as to permit state funds to supplement local funds more readily when township or other relief authorities are unable to meet the problem fully. Mr. Hilliard described present limitations and difficulties as follows:

> "Townships and other local units administering general relief should provide one of the chief sources of funds for paying costs for the indigent chronically ill. There are 1455 such local units. The State supplements local funds used for this purpose, provided the local unit has made a 3 mill levy and otherwise qualified for state relief funds which are allocated by the Public Aid Commission. At the present time, however, less than 200 of these units have made the required levy and thus have access to state funds.
>
> "A special problem is presented for the chronically ill who live in the City of Chicago and the Incorporated Town of Cicero. If they are already on the relief rolls, care can be provided for them at the expense of the relief officials in any suitable institution, public or private. If they are not already on the general relief rolls, however, the present Pauper Law makes the County of Cook responsible for their care, rather than the Chicago Welfare Administration or the Supervisor of the Incorporated Town of Cicero.
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> "The County of Cook restricts the care it offers to the services available in the Cook County Hospital or in the Oak Forest Infirmary, which is the poor house maintained by the County of Cook. The County of Cook does not have access to state relief funds allocated by the Public Aid Commission for care of paupers and care of the medically indigent. As a result of this situation, no public agency in the City of Chicago is at present meeting the costs of an indigent chronically ill person, not otherwise on relief, in a private nursing home or in hospitals other than the Cook County Hospital. Any such care given is left to private charitable agencies.
>
> "Amendment of this present provision of the Pauper Law to place responsibility on the relief officials of Chicago and Cicero, as it is in the other 1455 relief administering units, would raise some problems. For example, the practical effect would be to change the Cook County Hospital and Oak Forest Infirmary from county operated institutions to institutions operated by the City of Chicago, since the majority of the patients come from such city. This would destroy the advantage of having a county institution maintained by county funds. It is suggested that the Committee, if its life is extended by the Sixty-fourth General Assembly, give special study to the problem arising in Chicago and Cicero because of the present provisions of the Pauper Law."

Summary of Fundamental Questions to Be Considered

Dr. Kretschmer[1] has ably summarized the fundamental questions which must be considered in developing a sound public policy. Dr. Kretschmer says:

> "Before any sound program can be instituted, careful and serious consideration must be given to the fundamental questions, as:

[1] *The Journal of the American Medical Association*, April 21, 1945, p. 1027.

"1. The relative distribution of responsibility which should be maintained by voluntary, philanthropic and proprietary services for establishing and operating the necessary homes and hospitals.

"2. The responsibility which should be assumed by the government for the indigent.

"3. The desirable size and location of the facilities to be established.

"4. The extent to which beds are needed in hospitals or treatment centers as distinguished from homes for patients who cannot hope to profit from treatment and need only continued personal care and nursing attention.

"5. The most satisfactory method of financing care for patients unable to pay the costs of care, in whole or in part.

"6. The most effective means of maintaining adequate standards of care in institutions serving these patients, i.e., through licensing laws, periodic inspection by state or local authorities, and so on.

"Whether there are to be special institutions for the chronically ill, i.e., chronic disease hospitals separate and apart from those serving acutely ill patients, or whether they are to be separate wings or additions to these hospitals. Much discussion must be given to this question."

Such problems as those outlined above make it imperative that the work of the present Committee be continued during the next biennium in order that well-considered recommendations may be made to the Sixty-fifth General Assembly. In the meantime, certain immediate steps can and should be taken by the Sixty-fourth General Assembly. These recommended steps are discussed in the next and concluding section of this report.

CURRENT LEGISLATION ON THE CHRONICALLY ILL

Conversion of County Homes Into Facilities for the Chronically Ill: Rennick-Laughlin Bills (S.B. 210, 212, 213, and 534)

It has been mentioned previously that the Sixty-fourth General Assembly has already enacted into law the Rennick-Laughlin Bills which provide for additional facilities for the chronically ill by converting county homes into homes for the destitute, infirm and chronically ill and making such homes as meet proper standards accessible to Old Age Pension and Blind Assistance recipients without loss of their assistance grants. These Bills also make care in such homes accessible to borderline income persons who wish to purchase care therein.

> *The Committee views this legislation as the most important action taken in recent years to develop facilities for the chronically ill.*

Aid to Persons Afflicted With Cancer or Tumor

Three Bills have been introduced in the Sixty-fourth General Assembly pertaining to care for persons afflicted with cancer or tumor. These are Senate Bills 191 and 192 (Lohmann) and House Bill 55 (Hayne).

House Bill 55 passed the House April 10, 1945, and the Senate May 23. The Bill reduces the number of legal voters in the county required to file a petition for the purpose of submitting to referendum in the county the question of providing for treatment of persons afflicted with cancer or tumor, in accordance with the Act of May 12, 1943 which enables the counties to provide for cancer and tumor relief.

Senate Bills 191 and 192 propose the establishment of an Illinois State Cancer Hospital to be included among the State charitable institutions and supervised, managed and controlled by the Department of Public Welfare.

Care for the Tubercular

Three Bills have been introduced pertaining to care for the tubercular. These are Senate Bills 47 and 48 (Libonati) and House Bill 325 (Gibbs, Van der Vries, Powell, Stransky, Jenkins, Davis, Prusinski, Fred J. Smith, Sullivan and Ray).

Senate Bills 47 and 48 propose to create a State Tuberculosis Hospital Fund from a portion of the moneys received under the Illinois Horse Racing Act.

House Bill 325 proposes that the State of Illinois pay $1.50 per day for each tubercular patient receiving care at public expense from a sanitarium board or hospital approved by the Department of Public Health.

On April 5, 1945 the Senate concurred in House Joint Resolution 29 offered March 28 by Messrs. Nelson, Hannigan and James J. Ryan. This Resolution provides for the appointment of a legislative committee to study the feasibility and necessity of constructing a public tuberculosis hospital in the southeast and south portion of Chicago. This committee will consist of three members of the House and three members of the Senate. It is to report its findings to the present Sixty-fourth General Assembly.

Concerned as it has been with exploring the problem of chronic disease in its entirety, the Committee is not prepared at this time to offer recommendations concerning care of the tubercular but it does wish to call attention to the statement of Governor Dwight H. Green in his Second Inaugural Address, January 8, 1945. Governor Green said:

> "Illinois is the only state, except Nevada, which does not either maintain state tuberculosis sanitoriums, or subsidize local sanitoriums. With more than thirty-two hundred deaths and approximately ten thousand new cases of tuberculosis reported annually in Illinois, and the likelihood of higher prevalence after the war, the need of additional sanitorium facilities and a more aggressive and extensive control program is serious.
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> "The Department of Public Health has proposed, and I commend it to your earnest consideration, that four tuberculosis sanatoriums, of two hundred beds each, be constructed in downstate Illinois, and one or more, with an aggregate of two thousand beds, in Cook County. The estimated cost of construction, exclusive of sites, $7,570,500. The proposal has been officially endorsed by public health and tuberculosis organizations, and the American Legion.
>
> "The plans for these sanitoriums must be considered in connection with a unified and statewide post-war program, but I submit that effective state action to curb tuberculosis is one of the pressing needs of Illinois."

In accordance with Governor Green's recommendation, Senate Bill 417 (Peters and Ryan) includes in its proposed appropriation for a statewide system of public works projects, an item of $3,850,000.00 for the construction of tuberculosis sanitariums, with fixed equipment installed, one of which is to be located in Cook County, and four in other sections of the State. The appropriation is proposed for the Department of Public Works and Buildings.

Extension of Facilities for Physically Handicapped Children (H.B. 412: Van der Vries, Edwards, and Prusinski)

This Bill proposes important extensions of state aid and service to physically handicapped children. It includes a proposed hospital school which any educable handicapped person under the age of 21 would be permitted to attend.

This Bill has been endorsed by many persons interested in child welfare as well as those interested in improving facilities for the chronically ill and physically impaired. It may provide, among other services, some opportunity for the rehabilitation of spastic children for whom facilities are practically non-existent.

The Committee recommends this Bill for consideration by the Sixty-fourth General Assembly.

Regulation of Hospitals and Related Institutions

Three bills have been introduced in the Sixty-fourth General Assembly which propose the licensing and regulation of hospitals and related institutions. These bills are House Bill 103 (Welters and Granata), House Bill 252 (Gibbs, Van der Vries, Wellinghoff and Stransky), and Senate Bill 373 (Downing).

House Bill 103 proposes to license and regulate private hospitals, nursing homes and sanitariums. Responsibility for setting standards and issuing licenses is placed in the Department of Public Health. The proposed annual license fee is $5.00. Hos-

pitals maintained and operated by the State or by any political subdivision or municipality in the State do not come within the proposed regulatory provisions. Exceptions are likewise made for hospitals and municipalities which have by ordinance provided for the regulation of hospitals in accordance with at least the minimum requirements of the proposed Act. The bill does not specify the minimum number of persons required to classify an institution or home under the proposed Act.

House Bill 252 proposes that the Department of Public Health license and regulate nursing homes which care for three or more persons. Hospitals are not brought within the provisions of the proposed act. Homes or institutions operated by the Federal or State Governments or by subdivisions thereof are excepted. Limitations are set forth concerning the regulatory power of the State Department of Public Health over homes conducted for those who rely upon treatment by prayer or spiritual means. Cities, villages, or incorporated towns which provide for licensing and regulation of nursing homes in accordance with standards which substantially comply with the minimum requirements of the proposed act are excepted from coverage. The proposed original license fee is $25.00 with an annual renewal fee of $5.00.

Senate Bill 373 provides for the licensing and regulation of all types of hospitals and sanitaria, nursing homes, boarding homes, and other institutions providing hospitalization or care for persons requiring care by reason of illness, injury, physical and mental infirmity, or other disability. The power to license and regulate is placed in the Department of Public Health. The only hospital facilities excepted are those maintained by a penitentiary, jail or reformatory in which persons convicted of crime are incarcerated. It provides that the Director of the Department of Public Health shall appoint an advisory committee to represent each class of hospital or institution to be licensed. License fees are graduated according to the number of beds in the home or institution. Proposed fees range from $10.00 to $25.00.

> *The Committee has given careful consideration to all three of the above bills pertaining to the licensing and regulation of hospitals and related facilities. It recommends that Senate Bill 373 take precedence over House Bills 103 and 252. Senate Bill 373 is complete in its coverage and will thus assure protection to all Illinois persons. It also has the advantage of codifying previous licensing acts pertaining to special types of hospitals or institutions and centralizing authority in one state department.*

Legislative Commissions to Continue Study of Medical Care Problems

Two bills have been introduced in the Sixty-fourth General Assembly proposing the establishment of legislative commissions to inquire into the medical needs of residents of the State of Illinois and facilities for their care. These Bills are Senate Bill 336 (Crisenberry, Thomas and Fribley) and Senate Bill 436 (Bidwill and Downing).

Senate Bill 336 proposes a Commission to investigate medical and hospital needs of residents of Illinois. The Commission is to consist of three members of the House, three members of the Senate, and three members appointed by the Governor. In making his appointments, the Governor is required to give consideration to the recommendations of labor groups or organizations. This Commission is to report to the Sixty-fifth General Assembly its recommendations concerning the establishment of a State system of hospitalization and medical care.

It is recommended that this Commission, if Senate Bill 336 becomes law, cooperate in its inquiries with the Commission proposed by Senate Bill 436.

Senate Bill 436 proposes a Commission to investigate the need of developing facilities for the care and treatment of persons who are chronically ill. It provides that the proposed Commission consist of three members of the Senate, three members of the House, and the heads of three State agencies; namely, the Director of the Department of Public Welfare, the Director of the Department of Public Health, and the Public Aid Director of the Illinois Public Aid Commission. Through this means, members of the General Assembly and members of the administration most directly concerned with and technically informed about problems of the chronically ill, will be able to work together in pursuing further the investigations of the present Committee to Investigate Chronic Diseases Among Indigents.

Senate Bill 436 carefully outlines the field of inquiry of the proposed Commission. This is stated in the following language:

> "The Commission shall make a thorough investigation and study of the hospitalization and other care and treatment facilities available in this State for persons who are chronically ill, the adequacy of such facilities, the need of developing additional facilities for such purpose, the desirability of enacting enabling or corrective legislation to increase or improve such facilities, and all matters germane thereto. The investigation and study shall embrace both governmental and private facilities and needs and shall relate to all chronically ill persons. The Commission may study and consider the matter of making State contributions for hospitalization and medical needs of chronically ill persons who are destitute and unable to meet such costs."

This Bill relates directly to the work of the present Committee to Investigate Chronic Diseases Among Indigents. As previously indicated throughout this report, the present Committee has only begun to study the complex problem of the chronically ill. It is obvious that further study will be necessary to provide the basis for a sound public policy which will coordinate State and local planning for the care of such persons.

The inquiries and findings of the present Committee have established that the question of chronic invalidism is one of the most urgent problems in the welfare and health field confronting the State of Illinois. It, therefore, urgently recommends to the Sixty-fourth General Assembly that it act favorably on Senate Bill 436. This Bill will assure to the State of Illinois a careful survey of the entire problem, upon basis of which adequate plans can be made to meet the need in a manner consistent with the State's reputation for pioneer action in the field of public welfare.